Pinehurst Medical Clinic
GASTROENTEROLOGY

Name: Age: Date:

Reason for today's visit:

Please check box for any medical problems:

☐ Stroke ☐ Heart Trouble ☐ Diabetes ☐ Breast Cancer
☐ Seizure ☐ Heart Attack ☐ Kidney Disease ☐ Prostate Cancer
☐ Thyroid ☐ Irregular Heart Beat ☐ Arthritis
☐ COPD/Emphysema ☐ High Blood Pressure ☐ Depression/Anxiety
☐ Asthma ☐ High Cholesterol ☐ Anemia

Other Conditions

Please check box for prior surgeries/procedures (please include endoscopy procedures):

☐ Tonsils ☐ Hip Replaced ☐ Gallbladder ☐ Hysterectomy (uterus removed)
☐ Heart Bypass ☐ Knee Replaced ☐ Colon Surgery ☐ Hernia
☐ Heart Valve ☐ C-section ☐ Colonoscopy
☐ Back Surgery ☐ Appendix ☐ Upper Endoscopy

Other Surgeries

Family Medical History

List any medical problems that run in your family and who had them:

Has anyone in your family had uterine, ovarian, and/or colon cancer? ☐ Yes ☐ No (If yes, which form of cancer, who & at what age?)

Has anyone in your family had Crohn's disease, colitis, or pancreatic cancer? ☐ Yes ☐ No (If yes, who & at what age?)

Social

Who do you live with? ______________________

Are you? ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Are you employed? ☐ Yes ☐ No If yes, what is your job? ______________________

Are you disabled? ☐ Yes ☐ No If disabled, reason? ______________________

Habits

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? ______________

Did you smoke in the past? ☐ Yes ☐ No If yes, when did you quit? ______________

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? ______________

Do you chew tobacco? ☐ Yes ☐ No

How many cups of coffee per day? ☐ 0 ☐ 1-2 ☐ 3-4 ☐ >4

How many cans of soda per day? ☐ 0 ☐ 1-2 ☐ 3-4 ☐ >4

Please list your current medications and dosages:

Allergies:

Do you take ☐ Goody's or BC's ☐ Ibuprofen (Advil, Motrin, Nuprin, Aleve, or similar medicine)
☐ None

If yes, how many pills per week? ______________________

If there is anything else about your health you would like us to be aware of, please mention it here:

Preventative Care

Have you ever had a colonoscopy for colorectal cancer screening?

Please answer the questions on page 2 (over)

Please answer some questions about your general health. Date: ________________

			Please explain below symptoms you have currently:
Gen	Do you have any weight problems?	☐Yes ☐No	
	Have you lost weight recently?	☐Yes, how many lbs?______ ☐ No	
	Have you gained weight?	☐Yes, how many lbs?______ ☐ No	
	Any fever or sweating chills?	☐Current ☐Past ☐None	
Eyes	Do you have trouble with your vision? (other than needing glasses)	☐Current ☐Past ☐None	
	Do you have glaucoma?	☐Current ☐Past ☐None	
ENT	Do you have hearing trouble?	☐Current ☐Past ☐None	
	Recurrent nosebleeds?	☐Current ☐Past ☐None	
	Sinus problems?	☐Current ☐Past ☐None	
	Hoarseness?	☐Current ☐Past ☐None	
CV	Do you have chest pain or angina?	☐Current ☐Past ☐None	
	Shortness of breath?	☐Current ☐Past ☐None	
	Passing out spells?	☐Current ☐Past ☐None	
	Swelling of your ankles?	☐Current ☐Past ☐None	
GI	Do you have heartburn?	☐Current ☐Past ☐None	
	If yes, ☐daily ☐weekly ☐less than once a week		
	Do you have difficulty swallowing?	☐Current ☐Past ☐None	
	Nausea?	☐Current ☐Past ☐None	
	Vomiting?	☐Current ☐Past ☐None	
	Diarrhea?	☐Current ☐Past ☐None	
	Constipation?	☐Current ☐Past ☐None	
	Uncontrolled leakage of stool?	☐Current ☐Past ☐None	
	Rectal bleeding?	☐Current ☐Past ☐None	
	Black stools that look like tar?	☐Current ☐Past ☐None	
	Have you ever had hepatitis or jaundice?	☐Current ☐Past ☐None	
GU	Do you currently have ☐painful or ☐frequent urination	☐Current ☐Past ☐None	
	Blood in your urine?	☐Current ☐Past ☐None	
	Have you had kidney stones?	☐Current ☐Past ☐None	
	Abnormal menstrual bleeding? (women only)		
MS	Do you have		
	Joint pain or arthritis?	☐Current ☐Past ☐None	
	Back pain?	☐Current ☐Past ☐None	
	Prominent muscle soreness or aches?	☐Current ☐Past ☐None	
	If yes, where?		
NEU	Frequent headaches?	☐Current ☐Past ☐None	
	Have you had seizures?	☐Current ☐Past ☐None	
	Have you ever had a stroke?	☐Current ☐Past ☐None	
HEME	Have you ever had a blood transfusion?	☐Current ☐Past ☐None	
	Do you have severe bleeding tendencies?	☐Current ☐Past ☐None	
	If yes, please explain:		
PSYCH	Are you depressed?	☐Current ☐Past ☐None	
	If yes, would you call this depression: ☐Mild ☐Moderate ☐Severe		
	Do you have problems with your nerves or feel under excessive stress?	☐Current ☐Past ☐None	
	If yes, would you call this stress/nerves: ☐Mild ☐Moderate ☐Severe		
	Have you ever been a victim of sexual or physical abuse?	☐Current ☐Past ☐None	